Chapter 7

Healthcare Futures: Visions of Solidarity and the Sustainability of European Healthcare Systems

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Abstract

Four distinct visions of health care solidarity emerged from our Deliberative Forums on health care in the UK, Norway, Germany and Slovenia, which we term exclusive solidarity, universal solidarity, contributory solidarity, and equalitarian solidarity. These visions reveal national differences in citizens' ideas about the appropriate risk-community for healthcare, as well as the rights and duties of the members of this community. To some extent, these visions are related to the institutional organization of healthcare, and the history of healthcare institutions in these countries. They are often compatible with the attitudes expressed in large public opinion surveys. But the unusual opportunity provided by the Deliberative Forums for allowing participants to fully articulate their ideas and their justifications for their values also allows us to identify more coherent and measured rationales for these differences in public opinion, and their implications for the future politics of the welfare state.

Introduction

The literature on solidarity and deservingness has often focused on distinctions amongst different types of social risks, and on the impact of welfare state regimes on attitudes of

solidarity and deservingness (Petersen et al. 2011, Van Oorschot 2000, Arts and Gelissen 2001, Mau 2004, Van Oorschot and Komter 1998). When it comes to health, Europeans display higher levels of solidarity with the sick than do respondents in other continents, and in almost all studies of deservingness, the sick are singled out as being highly deserving of medical treatment (Abela 2004). The only exceptions and causes of variation are with regard to self-inflicted illnesses and persons that are viewed as not belonging to the political community. Scholars have found substantial empirical support for the propositions of these theories of solidarity and deservingness.

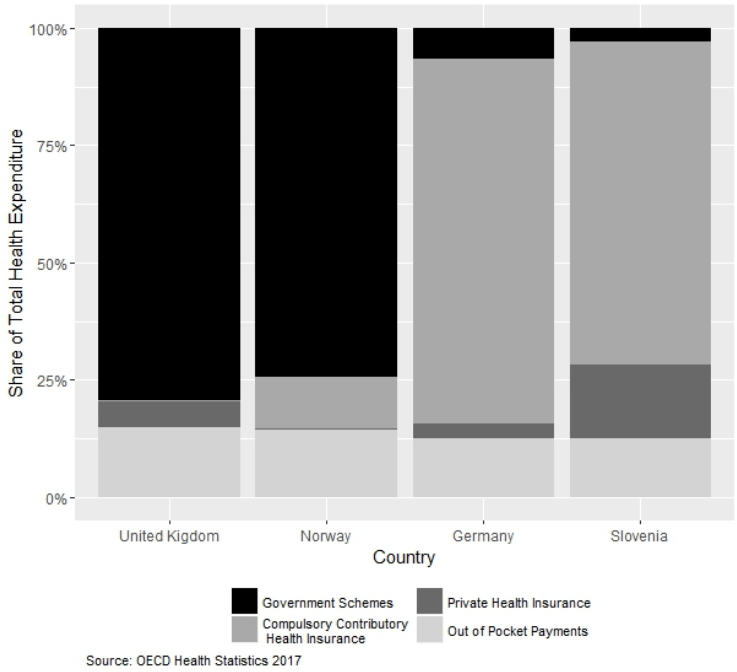
From our Deliberative Forums, however, a more nuanced view has emerged. The participants articulated very different understandings of the risk community and the basis for its rights and duties. This chapter analyses attitude patterns on healthcare solidarity and perceived levels of sustainability in four countries: the United Kingdom (UK), Norway, Germany, and Slovenia. In the United Kingdom, solidarity was *exclusive*, with high support for government's responsibility to the sick, but with high barriers to outsiders. In Norway, solidarity was *universal*. Participants supported provision for everyone regardless of citizenship, but were critical of special privileges and disregards for particular groups because this would undermine the idea of an equal common service. In Germany, solidarity can be categorized as *contributory*. Participants were concerned that all contributed fairly, and about the financial stability of the health insurance system in face of large numbers of non-contributors. Finally, in Slovenia, health solidarity may be coined as *equalitarian*. It is based on a socialist ideal of identical treatment of all, despite the reality of corruption which has become enmeshed with the capitalist profit motive.

To some extent, there are historical and institutional bases for these patterns. Norwegian universalism and Germany contributory solidarity can be traced to their social democratic and conservative roots, respectively. As can be seen in Figure 7.1, Norwegian healthcare is largely

tax-financed, and residents receive health services directly in public institutions. There is however a significant level of social insurance, as well as a very small proportion of private insurance financing. In Germany, by contrast, healthcare is largely paid for by social insurance carried by statutory sickness funds, with wage-earner contributions covering spouses and dependent children. Higher income workers, as well as public servants and the self-employed, generally opt out and are covered by private insurance. Thus, health insurance coverage is based on civil and occupational status, in line with the traditional conservative model. In a similar vein, attitudes in the UK and Slovenia can be related to their liberal and socialist roots—but here the picture becomes quite a bit more complicated. Although the UK is considered to be a liberal welfare state, its health system has the highest proportion of public financing in our sample—and the third largest in Europe, after Denmark and Sweden.

This is a general problem in the analysis of welfare state regimes. The institutional logic of healthcare systems often departs quite markedly from the supposed type of welfare regime (Bambra 2005). Perhaps nowhere is the discrepancy more glaring than in liberal welfare states. Although they do indeed share the common feature that the balance between state and market is decidedly tipped in the direction of market, the justification and meaning of these liberal restrictions is very different, and the public healthcare programs cover the entire range of variation in the public-private mix in health. Canada has a full single payer system with strong prohibitions on private medicine. The UK as well is largely single payer but includes a significant amount of private insurance funding. New Zealand follows the UK/Canadian model, but Australia is far more privatized. The United States is a great outlier with largely occupationally based healthcare in combination with special programs for the retirees (Medicare), the poor (Medicaid), as well as a comparatively large uninsured population (Béland and Gran 2008).

Figure 7.1: The Public-Private Mix in Health (United Kingdom, Norway, Germany and Slovenia), 2015[i]



Not only the exact public private mix, but also its historical development is quite relevant for understanding the impact of institutions on healthcare attitudes. Slovenia today has the least amount of government funding for health in Europe. But only a few decades ago—before its independence in 1991—it was 100 per cent public funded with no private healthcare. Not surprisingly, Slovenians complain about out-of-pocket payments and the unfairness of rules for social insurance contributions. At the same time however, and somewhat paradoxically, the level of unmet needs and the barriers to health services (as measured in public opinion surveys) are the lowest among the four countries analysed in this chapter (see Figure 7.3, below). The country currently follows the financing pattern of a conservative welfare state, but was socialist in the recent past, and the attitudes expressed in our forums fit this legacy.

Nevertheless, in all countries examined in this chapter, we see particular interpretations of solidarity that do not flow directly from these institutional and historical patterns. In each country, participants in the deliberative forums express opinions about who is to be included in

the health safety net, those that are to be excluded, as well as threats to their system and possible solutions. Indeed, participants in the Democratic Forums expressed significant criticisms of their health systems and raised fundamental questions about their social and political legitimacy. The next section offers a brief literature review and summary of the current empirical evidence from quantitative surveys. We then elaborate on these visions of solidarity and our evidence in the remaining sections of this chapter. We conclude with some speculation on the sources of these different visions and their implication for the optimism and enthusiasm with which these participants are prepared to adapt healthcare for the future.

Healthcare solidarity and deservingness

Deservingness theory aims to explain public attitudes regarding who is deserving of social solidarity. Empirical research has shown that five conditions are related to the degree of support for public aid to recipients: need, control, reciprocity, attitude, and identity (Petersen et al. 2011, Van Oorschot 2000). Support for social benefits is higher for those who are seen as needy, and when their vulnerable situation is viewed as the result of external forces out of their own control. Reciprocity refers to what is expected of recipients in return for aid, and attitude to behavioural expectations of recipients, for example being grateful for aid. Identity refers to the perception that recipients belong to one's own community. When it comes to healthcare solidarity, research thus far has focused mainly on whether health disparities are attributed to individual behaviours or to biological or systemic factors (Gollust and Lynch 2011, Rigby et al. 2009, Murphy-Berman et al. 1998). When illness is caused by individual behaviour (for example smoking, drinking, extreme sports) support for individual responsibility for healthcare costs is higher (and consequently demand for government provision lower) than when biological factors or events outside individual control, such as accidents are responsible for illness.

Cultural attitudes about deservingness may be influenced by institutional settings, however. As Larsen (2008) points out, different welfare state institutions may frame solidarity in terms of one or more of the deservingness criteria. Selective policies frame solidarity in terms of need and control by restricting social benefits to those in need and without control over their well-being. Consequently, such programs create a social cleavage between beneficiaries and contributors. Universalistic and more inclusive policies, by contrast, obviate the need to classify beneficiaries in terms of need and control, and thus foster a community of risk-sharers. As such, the level of solidarity is expected to be higher, and the cleavages less relevant. In a similar vein, Mau (2004) has developed the concept of reciprocity into a theory of the moral economy of welfare states. Here, he distinguishes amongst four distinct types of reciprocity, which in his view are the basis for social solidarity. These types are defined in terms of the extensiveness of provision—comprehensive or residual—and the extent of conditionality of benefits—weak or strong. Historically, most European health systems included charity (residual/strongly conditional) provision of healthcare through religious orders and the charitable practices of doctors and hospitals. As mentioned above, the US also maintains a means-tested health insurance program (Medicaid, comprehensive/strongly conditional), for which recipients must liquidate nearly all assets to qualify. But with the development of universal health coverage, nearly all European health systems provide comprehensive health benefits with few entry barriers. However, one could say that in a national health service system, such as the UK and Norway, conditionality and reciprocity is more generalized than under social health insurance, which has traditionally organized the insured into occupational or status groupings, such as the long-term German distinctions between civil servants, salaried employees, and industrial workers (Immergut 1986, 1992). Moreover, the extent of private health insurance, either as an opt-out of replacement for social health insurance or in order to cover supplementary services, may divide different pools of beneficiaries and contributors in healthcare systems. The effect is to foster contributory solidarity within specific risk communities rather than the generalized

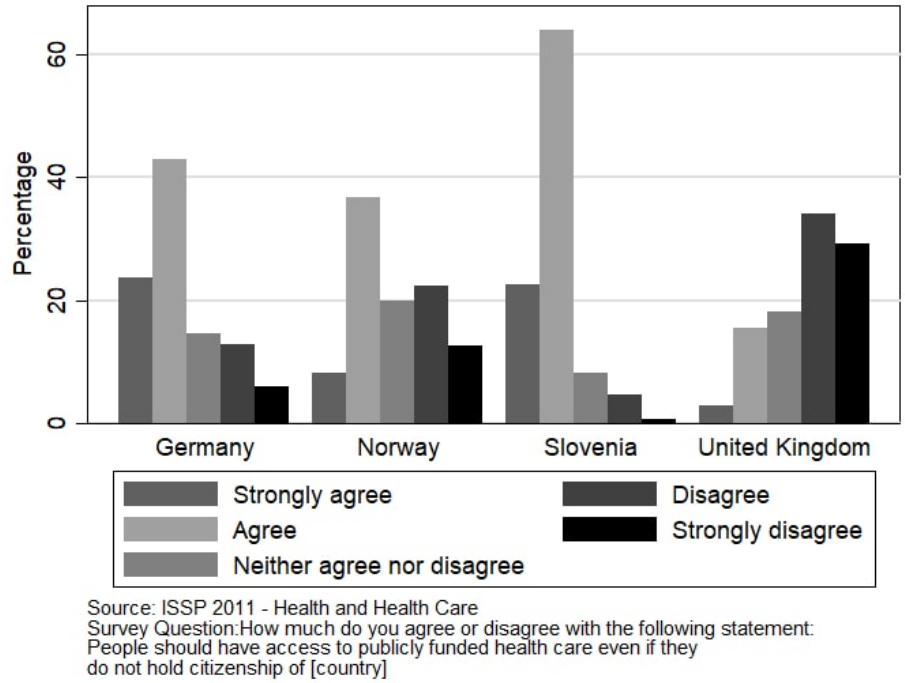
solidarity of the national health services. Further to the extent that private insurance and private out-of-pocket payments increase, we might expect both generalized and contributory solidarity to be threatened (Jordan 2010, 2013, Gevers et al. 2000, Maarse 2006, Maarse and Paulus 2003). Hence, the literature on deservingness and solidarity indicates that while solidarity for the sick may be generally very high, there may be important variations based on the specific institutional arrangements in place in a given country.

If we turn now to the results of large scale surveys, we observe results much in line with the theoretical literature. Healthcare solidarity is high in all four countries. In answer to a question in the 2008-9 ESS about whether governments should be responsible for healthcare for the sick all four scored above eight on a ten-point scale (UK – 8.7, Germany - 8.3, Norway – 8.9, Slovenia – 8.6). The International Social Survey Programme (ISSP) 2011 Health and Health Care results show strong opposition to the idea of limiting publicly funded health services. More than 70 per cent of the population of each of the four countries disagree or strongly disagree with the proposition that government provided health services should be limited (ranging from 73 per cent in Germany to 76 per cent in UK). However, when asked if younger or older persons should be given priority in access to health treatment, public opinion in all four countries is divided between those who think that young people should have priority and those who think age should not matter. When asked who should have priority between a 30-year-old and 70-year-old who need a similar heart operation, around 40 per cent of the people in each country answered in favour of the 30-year-old, while, about 50% of those in each country believed age should not matter when choosing between the two. In sum, the sick tend to be viewed as deserving of government healthcare in all four countries, with strong opposition to limitations on healthcare coverage, and no consensus on rationing by age.

We do however observe higher discrepancies between countries when it comes to analysing socio-economic differences in health access, healthcare rights for migrants, and whether

healthcare entitlement should depend on behaviour. The UK is the country with the highest percentage of people who believe that it is very or somewhat fair that higher income groups should have access to better healthcare (28.6 per cent), followed by Norway (12.2 per cent), Germany (7.2 per cent) and Slovenia (7.7 per cent).

Figure 7.2: Support for Public Healthcare Provision for non-Citizens, 2011



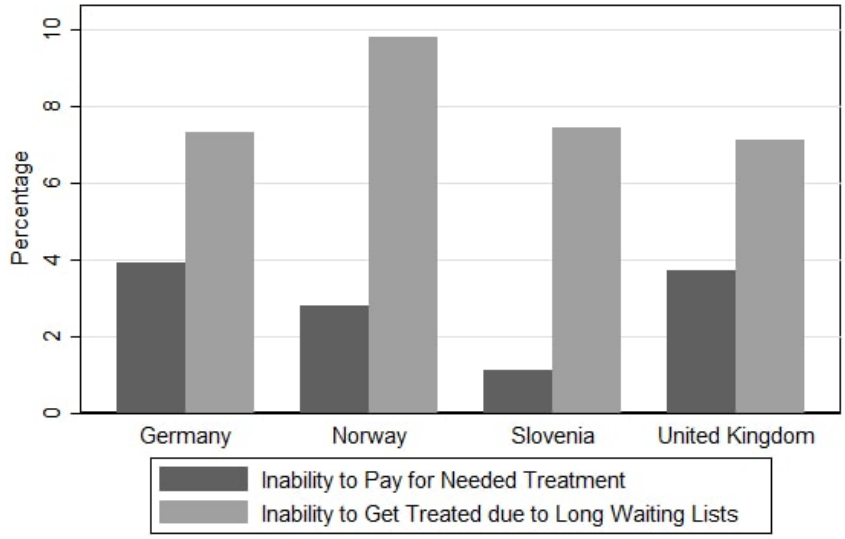
Source: ISSP 2011 - Health and Health Care
Survey Question:How much do you agree or disagree with the following statement:
People should have access to publicly funded health care even if they
do not hold citizenship of [country]

Regarding access to publicly funded healthcare for non-citizens, the level of support is high in Slovenia and Germany, with 86.5 per cent and 66.6 per cent of respondents, respectively, agreeing or strongly agreeing that non-citizens should have access to healthcare (Figure 7.2). By contrast support for providing healthcare to non-citizens is moderate in Norway (45 per cent agree and strongly agree) and rather limited in the UK (with only 18.5 per cent of the people agreeing or strongly agreeing, and with a clear majority of 63.3 per cent disagreeing). As predicted by deservingness theory, and in line with other studies, fewer respondents support public healthcare provision for individuals that engage in behaviour that is damaging to health,

but more than 50 per cent of respondents in Slovenia and Norway agree that these persons are entitled to publicly funded care, while 40.1 per cent and 50.6 per cent of respondents in Germany and the UK disagreed that these persons should be entitled to publicly-funded healthcare. Thus, we observe important differences in our country-respondents, but they are not immediately traceable to healthcare institutions. German and Slovenian respondents are most open to non-citizens, while Norwegians and Slovenians are most tolerant of health-damaging behaviour. And those in the UK are most accepting of better healthcare treatment for the well-off.

Turning finally to respondents' evaluations of their national health systems, we note that respondents in all four countries were largely satisfied with their health systems (in all countries the average was above 3 on a 4 point scale). Respondents in Britain were most willing to pay higher taxes in order to improve their health system, with 39.7 per cent of respondents stating that they were very willing or fairly willing to pay more, in contrast to 29.1% of respondents in Norway, 27.3% in Germany and only 20.5% in Slovenia. Somewhat surprisingly, respondents in Slovenia reported the lowest financial barriers to treatment, and respondents in Germany and the UK the highest financial barriers (3.9 and 3.7 per cent), whereas in terms of capacity, respondents in Norway reported the highest capacity barriers to health access, with almost 10 per cent of respondents stating that they were unable to obtain treatment owing to overly-long waiting lists (Figure 7.3). Relatively low perceived barriers for treatment due to waiting times in Slovenia are somewhat surprising, as long waiting lists for several specialized treatments are one of the key problems of the healthcare system and continuously receive a lot of media attention. However, access to general practitioners is very good and this might explain relatively low perceived barriers in Slovenia.

Figure 7.3: Barriers to Health Access- Inability to Pay for Needed Treatment & Long Waiting Lists, 2011



Source: ISSP 2011 - Health and Health Care
Survey Question: During the past 12 months did it ever happen that you did not get the medical treatment you needed because:
a) you could not pay for it?
b) the waiting list was too long?

Thus, despite high levels of support for government provision of healthcare in all four countries, there is considerable variation in the conditionality of support and in the groups included. Respondents in Slovenia and Germany are most supportive of the provision of public healthcare to non-citizens, whilst respondents in Germany and the UK are most critical of those with damaging health behaviour. Surprisingly, respondents in such a rich country as Norway report difficulties in obtaining medical treatment because of long waiting lists, while in Slovenia, the poorest country, respondents report the least difficulties in obtaining treatment, either because of financing issues or waiting lists. In terms of private payment for superior treatment, respondents in the UK are most accepting, while those in Germany and Slovenia are most opposed.

While these large-N surveys can provide a point of departure for understanding welfare state attitudes, they do not offer clear explanations over why respondents in these countries express

the attitudes that they do. In order to explore the rationales and justifications that underlie these opinions and attitudes more deeply, we now turn to our Democratic Forum results.

Empirical analysis of the Democratic Forums

In this section we present the analysis of the democratic forums in relation to the issues of solidarity within the healthcare system as they were expressed by the participants in the four countries (the United Kingdom, Germany, Norway, and Slovenia). (The specific coding used is indicated in Table 7.1, below). We focus our research on 1) the inclusiveness and conditionality of the solidarity expressed by participants; and 2) how participants relate their perceptions of problems and proposed solutions proposed to these solidarity issues. Thus, we identify the groups with whom solidarity is acknowledged, and those that are excluded or seen as abusing solidarity. We analyse the ways in which deservingness criteria are applied, the consequences in terms of who is viewed as deserving and responsible, and on what kind of arguments solidarity is based. Furthermore, we also link the discussions of solidarity with the problems of the healthcare systems people identify and the solutions they propose to address these problems. In addition, we present briefly the data from survey carried out before and after the Democratic Forums, using selected standard attitudinal questions in relation to health care, to illustrate the general attitudes of participants and (potential) attitudinal changes.

Table 7.1: Coding list

Issue	Coding	Examples
Solidarity with whom	Included	Listing the deserving such as nationals, hardworking people…

	Excluded	Those that abuse the system, health tourist, those going private, migrants, the irresponsible…
Arguments used	Behaviour	Irresponsible health behaviour, abuse, etc.
	Identity	Was the argument based on the specific identity (nationals vs. migrants)?
	reciprocity	Was argument based on past contributions?
	Other	
Perceived issues relating to healthcare	Problems	How is the problem understood: sustainability, quality or something else
	Solutions	Solutions given, such as changing the insurance principles, privatisation

The four types of healthcare solidarity

As expected, based on attitude surveys, all countries express relatively high levels of solidarity, however, different versions of solidarity correspond to each due to the differences in the level of inclusiveness and understanding of the basis for solidarity and arguments used. We identified significant differences when observing the arguments on which the healthcare problems and solutions are discussed resulting in a more complete picture of healthcare solidarities.

United Kingdom

In the UK, we observe what we describe as e**xclusive solidarity**. This type of solidarity defines the relationship between the community and individual, and in particular the rights and

responsibilities of individuals, with an emphasis on the latter, as well as the limits to solidarity. The emphasis of the discussions on the healthcare system was on restricting the criteria for inclusion and therefore solidarity to certain groups of the population. The key criterion was nationality, which corresponds to the "identity" criterion for deservingness (van Oorschot 2000). While this was the most important criterion in the discussions, socially responsible behaviour, the "reciprocity" criterion, played a significant but secondary role. In this regard, the deserving are the social groups who are characterized by working hard, paying taxes, and financing the NHS—or being old and having special needs which need to be taken care of. They are in fact seen as a group who has financed the system and is therefore entitled to its services. Here the reciprocity as well as the need criteria are applied.

On the other side we have the undeserving that are excluded from solidarity. In this regard, the NHS is perceived as a system which needs to be protected and shielded from outsiders. Linked to the predominant identity criteria for deservingness, the social groups to which the solidarity principle does not extend are especially immigrants, and also health tourists, foreigners and EU nationals living in the UK, who, in the eyes of our participants in the Democratic Forums, threaten the sustainability of the health system. Here solidarity reaches its limits:

"Well some people just come for the Health Service, … they come over here for twelve months because they know there's a problem and they'll get seen to straight away whereas in the US you know or whatever you have to pay. "(UK - 88)

"The NHS is one area that we are saying that we spend a lot of money on, so I mean in this case with non EU nationals, you know, it's fair enough that they don't have access to the NHS. (UK - 40)

In addition to 'the outsiders', there are those 'from within' who are also seen as exploiting the system. One such group identified by participants are the unemployed: *"There is more time to*

think about the fact that you might have something wrong, because when you are at work all the time you just get on with it don't you and plough on?" (UK - 44)

Another group which seems to be set outside the solidarity principle are the ones who are irresponsible in regard to their health. Here the criteria of personal responsibility or control for deservingness can be observed. Irresponsible health related behaviour such as overeating and lack of exercise qualifies an individual to be placed outside the solidarity principle. *"I think keeping people healthy, or making them, again, more self-conscious on their own wellbeing [is a priority]." (UK - 64)*

On the other hand, there are some social groups who are perceived also as non-deserving simply because of the fact that they have enough money to afford private healthcare. Some participants felt that solidarity should be reserved for people who cannot afford private healthcare and not for those who can afford private services, putting forward the criteria of need and means-testing. Solidarity within the NHS is therefore viewed as solidarity with those who are in need of care, if they of course fulfil the above criteria of deservingness. *"I think it's more for the people that aren't like ourselves that can afford to pay for it." (UK - 81)*

The UK seems to stand out in this regard as the majority of the debates have been dominated by the notion of (un)deservingness. These topics have been present in debates in other countries but have nevertheless not been as strong or emotionally charged as in the UK. The criteria for defining the undeserving others has often been based on identity (for example, immigrants vs. natives, EU vs. non-EU nationals). This can also be seen in the identification of the problems faced by the healthcare system. In the UK, immigration is perceived as a major threat to the sustainability of the healthcare system as it leads to the overcrowding of the NHS, and thus threatens the access of the deserving. Here, we see the greatest difference in the perception of threats to sustainability: only in the UK is there a widespread wish to keep outsiders from entering the healthcare system.

"Yes, it was very, very similar. We were saying we anticipate that in 2040 we'll still have the same issues that we personally do now but it will probably be tenfold. Overcrowding which will lead to housing issues, not enough social housing, strain on the NHS, strain on education and who is going to pay for it? (…). So stricter border controls, making the right people come to the country, not just anyone and everyone and the prevention for people coming here to get healthcare really. They're coming here on a trip knowing perhaps that they're poorly or need help and then going to the doctors while they're here. That's it really." (UK - n.i.)

The solution to this identified threat is submitting the outsiders to tighter eligibility controls and stricter monitoring. In this regard the first policy proposed is to prevent extensive immigration to ensure the sustainability of the healthcare system.

"Prevent people coming in just to get healthcare or you know, things like that. They can't just come in to get benefits, I know that but you know if they needed to see a doctor, then they can see a doctor, and, you know. Money that we do have should be spent here, rather than sending it abroad." (UK - 44)

What can appear as somewhat surprising are the pragmatic attitudes towards privatisation. One would perhaps expect a more emotionally driven response especially following the positive as well as protective attitudes towards the National Health Service (NHS). Privatisation is however considered almost as a given and a suitable response to sustainability problems, criticism of NHS financing and over-bureaucratisation and seems in line with reluctant individualism (see Chapter 2 and Taylor Gooby et al, 2017). It is not that the participants all agree on systemic policy measures but they do feel something has to be done in order to assure the functioning of the NHS in the future.

"I think in – not that I want to, because I think I pay enough tax, but I think we probably do need to. The only way you are going to increase the amount of money we have got is to increase

taxes. But as part of that, what if, say, the NHS was optional. So I can choose not to get free healthcare, but then that would come… I would get like a tax subsidy for that. I wouldn't pay as much tax." (UK - 86).

All of these discussions were also reflected by results of the survey carried out amongst the participants of the forums. Namely, seeing healthcare for the sick as a government responsibility dropped after the forum as compared to the attitudes before it, bringing UK from having the highest support for government responsibility for the sick amongst the four countries to having the lowest ratings amongst the four, while the share perceiving the public healthcare system as unaffordable in the future was the highest (see table 7.3).

Germany

The corresponding debates in the German democratic forums focused on the concept of solidarity in and of itself. Indeed, we see here a debate on the core principles of the conservative welfare state regime, which divides beneficiaries according to occupational status. As we shall see, these divisions and privileges were openly questioned on grounds of fairness and sustainability. Furthermore, increased possibilities for leaving the public insurance system seem to have exacerbated the public-private health insurance divide in Germany. There were also discussions on deservingness, but there is no vested emotional interest in the debate as in the UK, but instead a more pragmatic approach emerges. This approach is not concerned with identifying the social groups who are taking advantage of the system, but more with systemic reflection on sustainability of the healthcare system in the long run. The German debate in regard to solidarity thus seems to be much more pragmatic and more inclusive and can be categorised as *contributory solidarity*. The emphasis was often on the desire to expand the community of contributors in order to make the system fairer and more sustainable, rather than to prevent outsiders from entering the system or to exclude misbehavers from coverage.

This is perhaps the reason behind the dominance of the private-public split concerning questions of solidarity. Participants express mixed attitudes toward increasing the share of private health insurance in Germany. The more dominant voices in the debate saw the private provision of services as the biggest threat to the solidarity in the German healthcare system and a sign of inevitable changes, which are about to come. *"The biggest problem is health insurance where 15.5% are in private schemes. That's a scandal." (DE-27).* The outrage some of the participants of the forums express has to do with perceived development of the German healthcare system into a two-class system, with privileged groups enjoying better treatment than those with compulsory public health insurance.

"But we don't have a real solidarity system or shared risk pool. Self-employed people are excluded from this, public officials are excluded…if it were a real shared risk pool system, then it would probably work better. The architects have their own system, pharmacist have their own, doctors have their own insurance…if they would all pay in with these good incomes, the state healthcare system would be a lot better off overall and work better." (DE - 11)

Some participants are resigned to contributory equity, with different outcomes in relation to different levels of contribution: "*But if that's the way it is, those who pay more should get more out of it, more services. (DE - 10).* But others are not:

"Because it's unequal treatment of patients. One may not believe it, but when state-insured people go to the doctor and they get a diagnosis from their doctor and need a specialized treatment, like an MRT scan, then you have wait times of three to six months in the best case, whereas a private patient gets the diagnosis, and then the doctor just makes a call and can send the patient right over to another practice for the test without wait time." (DE - 29)

Despite some extremely critical views on private insurance in Germany, it was still also proposed as a solution to the problem of sustainability of healthcare system, indicating mixed

attitudes. Some of the participants see it as a remedy and being in the role of assuring the fairness of the system.

"I intentionally got private, because there are benefits there that I want and have paid for, which I would otherwise not have. And then with the question of retirement pension, I don't want to be dependent on a system where I have to watch and see whether there are enough young people coming up who can then pay for my bills. Instead, I'll build up my own retirement savings. I think that is more just and fair." (DE - 34)

Thus, the concern is both with the sum of resources available to the public system, and with differences in treatment of public versus private patients. Support for providing universal healthcare access remains strong, however: *"Adequate medical care for each and every person, those who've paid and have not paid, homeless people, whoever." (DE - 5).*

As in the case of the UK, participants in Germany also discussed undeserving 'insiders' who do not exercise individual responsibility when it comes to choices they make in regard to their lifestyles and health behaviour. Similarly, participants criticized those who visit doctors too frequently (again showing irresponsible use of the system).

"It's about people. At my age, I know people who go to the doctor too often. When I go to the practice, I see some young people, and if you're sick you're sick, but I sometimes get the feeling, particularly with my generation, that going to the doctor really becomes a hobby." (DE - 11)

Nevertheless, the discourse of the debate is less harsh towards them than in the UK, and therefore the responsibility/control criteria were relevant but not the main argument for determining the level of solidarity. The limits to personal responsibility were recognised and also the need to educate people about healthier lifestyles.

"Here with personal responsibility, the state has the smallest role to play, but you can achieve quite a lot with relatively little effort through education and these stoplight labels showing how much sugar, fat and so forth are in things." (DE - 24)

The threat to solidarity is also detected from outside. In this context the refugee crisis is briefly mentioned. Here the contributory basis of the system is questioned as refugees are perceived by participants as a sustainability issue. They do not pay into the system, and their high needs could sink it:

"The problem is not getting better. We're supposed to be talking about the future, and this is getting worse, isn't it? I'm thinking about millions of refugees who don't pay into the system, but are still covered, and there I see a catastrophe coming in the future if I'm honest." (DE - 18)

The criterion for deservingness is not so much based on identity as in the case of the UK, and views on refugees seem to be more pragmatic and less emotionally charged. Meeting the needs of refugees is perceived as a sustainability threat that affects a contributory as opposed to a tax-based system. It is thus a financial issue not a deservingness issue.

Norway

Interestingly, in **Norway** the solidarity issue hardly appears in the context of deserving and undeserving social groups. It seems that the solidarity with different social groups is assumed due to strong support for the universal features of the system. Thus we can talk about **universal solidarity**. This type of solidarity presupposes protecting a common good that should be universally accessible. An additional issue is the quality of the services. While there is strong support for universal access to high-quality services, however, there is marked concern both

about the limits to growth of such a system and the moral basis of any effort to prioritize or ration.

On the one hand, participants are aware of the fact that prioritising is inevitable due to sustainability issues, so that it can be seen as a possible solution to the problem of excess demand:

"There has to be a limit for what to treat. Many elders would actually rather die a natural death, but if the heart stops a little when in a nursing home or a retirement home, they are bloody sent away in an ambulance to receive CPR. (...). That is wrong prioritizing." (NO - 30)

However, some also disapprove of the concept of prioritising, which is viewed by the participants of Norwegian democratic forums as a threat to universally accessible medical services and eventually a threat to solidarity, and is therefore identified as a problem of the healthcare system. Even more importantly they are aware of the ethical and moral dilemmas it brings to the forefront and to the logic of the healthcare system in general. The criterion of need is therefore important and the greater the need the more solidarity with the person. However, there also seems to be a limit to this criteria, and very high healthcare needs must be balanced by other issues (including reciprocity) when priorities are set.

"I feel that just this thing with prioritizing is a very difficult philosophical and ethical question, because there are many ways to do it. The doctors have made a promise – to save lives no matter the cost. We can use the throw-dice-model which is fair or unfair depending on how you see it, and one can use a type of business-case argumentation; what are the chances that this person will contribute to the gross national product or to tax income and so on?" (NO - 29)

In spite of undeniable expressions of support for universality, there seems to be what we can describe as the notion of choice becoming a growing element in the concept of social justice affecting also the solidarity features and consequently the support for certain health policies.

This is also linked to privatisation as a problem and a solution for the future of the healthcare system. The participants emphasise the need for principle of equality playing the lead role. However, even here, solidarity with more vulnerable members of society is taken into consideration and the health services as a universally accessible common good is respected. *"I feel that if you have worked and earned that capital, you should have the right to spend the money to buy that service, so long as you don't steal somebody else's place in line, somebody who doesn't have the money." (NO - 9)*

The public/private debate in Norway is not as polarising as in the case of Germany. Participants believe that the two sectors can co-exist and not erode the principle of solidarity and equality. Those taking up private insurance and unburdening the public healthcare system could therefore also be seen as exhibiting solidarity by taking more (individual) responsibility for their healthcare as they are making the health system financially more stable.

"I hope and think we have a public health service on the level it is today and that we have a private health service in addition to that." (NO - 21)

Even when it comes to immigrants, the participants do not take a radical view but express solidarity with them and the identity criteria of us vs. them is not applied. They are seen as a special vulnerable group from the perspective of health services provision. It almost seems as if the forum wants to make them part of their community as soon as possible.

"I think about integration. I haven't defined immigration slash immigrants. Not only thinking about refugees, but important to integrate everyone regardless. For example, through language teaching, working life, Norwegian culture. They who suffer from trauma get treatment for that." (NO - 2)

There are however certain groups to which the deservingness principle does apply but more weakly. This can be shown by the stress laid on individual responsibility for one's own health, therefore applying the control criteria of deservingness.

"But I think that one also has to take responsibility for one's own health. If you choose to eat McDonald's three times a week, not to work out, and lose everything because of drink, that is your choice. But then I don't necessarily think that you should get the same health service as the one who takes care of himself." (NO - 14)

In Norway the weakening of the solidarity principle is linked to individually and socially irresponsible health related behaviour, over usage of medical services and abuse of the rules which apply to the concept of prioritising.

Regarding objectivity, we think we have a very logical healthcare service, but I don't think so. As a health system worker, if I need an appointment, I will get it within the next 14 days, even if the wait is 6 months, because I know the system. If you are a journalist or politician, you get the same treatment. Not because they are the elite, but because they will make a hell of a fuss and hospitals aren't too keen on fuss. So nice and quietly one just treats that patient. That's how it is today. Maybe we need more objectivity. I want that. Maybe it could be a computer that says" You didn't make it to the top. You have to wait another three months even though you are a politician" Right? Because you are the same as everyone else. But today we have a kind of elitist discrimination, because one takes the one who makes the most noise, they are treated first, because then things go so much smoother, but it's not right that way. (NO – 24).

It is therefore the actions of individuals which set the weakening of solidarity in motion, the actions that threatens the common good, and not certain social and cultural features of groups of individuals. This is in stark contrast to the notion of exclusive solidarity in the UK.

Slovenia

Slovenia seems to resemble Norway in regard to solidarity principles. Participants from both the Norwegian and Slovene Democratic Forums express support for universalism as the main principle in policy design of their respective healthcare systems, although egalitarianism along with distrust of private healthcare provision was much more pronounced in Slovenia. Hence, the type of solidarity attached to such characteristics can be identified as *equalitarian solidarity*. As it is based on the belief in a common public good, universal coverage is essential and private insurance is seen as a threat to the continuity of the public healthcare, with extremely negative consequences for public health in general.

"I see it this way, if there isn't any money for public healthcare, this will become a problem. You will have to pay for every service and think twice before signing your child up for a procedure, or yourself actually on some tests that will cost a couple of thousand euro, that you perhaps won't have on an account somewhere, and that will cause, it will increase the mortality. That the people will not be prepared to finance that, if we allow everything to fall apart or if there won't be enough funds for that." (SI - 77)

It seems that exclusion criteria do not exist in Slovenia as almost no groups were discussed as potentially excluded and the belief in universal coverage of the healthcare system is unchallenged. The healthcare system, as is the case in Norway, is perceived as a public good. This could be the reason why the level of trust in the proper functioning of the healthcare system and its ability to ensure fairness and equal treatment for all is even more important. Inequality and equality of access have been the main topics when it comes to discussing the solidarity within the system. Due to the egalitarian views of the participants in the Slovene democratic forums, the perceived inequalities, which have in their opinion become inherent to the Slovene healthcare system, are unacceptable. Consequently, as one of solutions proposed was increasing the equalitarian principles so that supplementary payments in the system should be based on

income (as already the case with obligatory health insurance), which participants perceived as fairer than the lump sum payment for current supplementary insurance. *"It is not fair that we are all required to pay the same insurance, regardless of our income; whether we earn 5,000 EUR, 1,000 or only 500 EUR a month." (SI - 58).* The private co-payments for health insurance are therefore highly distrusted and seen as a way of making differences between people that are not acceptable and are also leading to erosion of sharing the risks. This attitude is strong among the general population and is reflected also in the recent policy developments as the new proposal of healthcare system reform includes the abolishment of existing individual co-payments (through private health insurance schemes).

When the level of trust in the system's ability to ensure equality is low and this is more and more the case in Slovenia, solidarity with different social groups does not diminish, however, those groups who are taking advantage of the system seems to be sliding out from under the solidarity umbrella. This is particularly evident in queue-jumping, which creates a division in the otherwise uniformly accessible provision of health services. It divides the population between those who can afford private medical services, plus those with the connections to "jump the queue" in the public system and those who cannot do either. Social and economic capital enables a part of population to afford better health services and to become "the other from within". *"Let's say that, if you need to see a doctor and the waiting list is too long, but if you go to a private practice, you get seen much sooner, that's not fair. It's not a given that you have the money for the private practice" (SI - 87).* Waiting lines are therefore a symbol of deeply rooted systemic problems. In this regard, private healthcare is perceived as the cause for eroding universalism.

"There are already long waiting lists to see doctors as it is, while the medical professionals are under a lot of strain, which only contributes to longer waiting lists. (...) The long waiting lists will backfire and not far in the future, in 25 years, but much sooner than that." (SI - 50)

In Slovenia the discussions of solutions to financial sustainability and demographic change that were the main identified problems of the system, as in Norway, remain firmly based on universalistic principles. However, in contrast to Norway, there is virtually no positive aspect to be found in the Slovene debate in regard to privatisation as a solution to sustainability problems of the system. Privatisation is linked to differences in quality of the services and their accessibility. People who can afford to use private practitioners are entitled to higher level of services which supports participants' belief that the universalism of the system is being eroded. This debate further supports the value system of Slovenes and their attitudes towards solidarity. Privatisation is generally perceived as a threat to otherwise universal and uniform service provision.

"So, someone who can afford to go to private practice, will receive a higher quality of service than someone who can't afford that. And I see this here as quite a problem." (SI - 86)

"I think I am in favour of cancelling private health care. Because what it really is, is: we all like to say that health is worth more than wealth, yet those who are not able to afford specialist check-ups because of financial difficulties, are what, simply supposed to die? So the specialists are only working for the privileged ones. I support the fact that doctors should be well paid, even paid double the money, if they work double the time, because they are able to work such long hours; however, those who work in public institutions in the morning and in private practices in the afternoon, that means, have a full time job and run their own practice, I cannot be in favour of that. They should only work in public health care, in their regular working hours and be paid well for it, so that everybody can have equal access to health care." (SI -57)

This distrust of the private provision in either form, through private health insurance or private practices (that can be paid out of pocket), distinguishes Slovenia from other countries, where despite some mistrust also positive views or partial acceptance of the private sector can be observed, especially in the light of sustainability problems. It seems to reflect the disillusioning

or inherent mistrust of the populace of what the capitalist society with private market provision within the welfare mix will bring to improve the quality of life of all. This is linked also to the common issues of corruption and high earnings or double earnings in the private healthcare sector (i.e. doctors working in public as well as private healthcare). It is also reflected in high support for government as actor responsible for health care for the sick, which after the forum according to the surveys increased and lead to Slovenia having the highest expressed support among the four countries. The surveys also reflect the lack of worry for the sustainability of future public health care system, as the highest share of respondents answered that public health care spending will be able to increase in next 25 years (19% compared to 7% or less in other three countries, see Table 7.3).

Table 7.2 Summary of healthcare solidarity issues addressed in Democratic Forums

Solidarity type	**Exclusive solidarity**	**Contributory solidarity**	**Universal solidarity**	**Equalitarian Solidarity**
Country	UK	Germany	Norway	Slovenia
Included	working hard poor old British	Solidarity with all coupled with concern that all then indeed contribute	Solidarity with all	Solidarity with all
Excluded	Immigrants Abusers Over-users Health tourists EU nationals	Abusers Over-users Irresponsible (Refugees/immigrants)	Irresponsible Over-users Abusers	Abusers
Description	A beautiful island to be defended against invaders	High solidarity with worries about two class approach	Protecting the (good) commons	Solidarity based on egalitarianism; distrust of capitalism
Problems perceived	Immigration Ageing of population Risk behaviours	Financial sustainability Private health insurance	Ageing of population Prioritizing	Ageing of population Privatization Corruption

	Financial sustainability	Ageing of population Refugees/immigrants Two class medicine	Financial sustainability	
Solutions proposed	Increased control and reduced eligibility (for migrants) Increased personal responsibility Possible privatization Choice (not to receive care)	More universal system with universal contributions less unequal treatment Increased personal responsibility Privatization as addition to public system	Privatization as addition to public system Increased personal responsibility Prioritization Choice (not to receive care)	Increased control and regulation Increased personal responsibility Pronounced egalitarianism (e.g. income related payments)

Table 7.3. Selected results of the survey among DF participants

	UK	NO	DE	SI
Health care for the sick is governments' responsibility (before)	9,2	8,9	9,0	8,8
Health care for the sick is governments' responsibility (after)	8,2	8,7	8,8	9,3
Governments should spend more on healthcare (after)	70,6%	68,8%	72,7%	83,8%
Level of public health care will not be affordable 25 years from now at present level (before)	72,7%	40,7%	39,4%	48,6%
Level of public health care will not be affordable 25 years from now at present level (after)	79,4%	53,6%	46,9%	41,7%
Public health care will be able to afford to increase 25 years from now (before)	12,1%	7,4%	15,2%	20,0%
Public health care will be able to afford to increase 25 years from now (after)	2,9%	7,1%	7,1%	19,4%
n	34	28	32	36

Note: before and after in the brackets refer to the survey questionnaire carried out before the Democratic Forums and after Democratic Forums.

Discussion and conclusion

The four visions of healthcare solidarity that emerged from our Democratic Forums show that the principles of solidarity remain strong but that they vary significantly between our countries, and have different consequences for the future outlook of these health systems. In the UK, the National Health Service is perceived by DF participants as "a thing of beauty"—as one participant put it—that must be defended from outsiders. Indeed, even though there were some concerns with those who abuse or overuse the healthcare system from within, it was not the main focus of the UK's exclusive solidarity, which is defined as against the other, whether these are 'health tourists', European Union Nationals or other groups. Returning to our survey data, exclusive solidarity is a vision that makes sense of the perceptions that increased taxation is necessary to pay for adequate services, that financial barriers to access are too high, and that even allowing unequal health access in order to unburden the public system may be necessary. Even though participants highly value the NHS and are generally satisfied with it, they feel a need to defend it against illegitimate use by outsiders, and may be disappointed that the government does not sufficiently defend it.

In Germany, the equivalence principle of contributory equity was the subject of debate in our Forums, and indeed, in German public debate. The privileges at the heart of the Conservative model were questioned, and the ability to purchase better treatment was criticized. Nevertheless, the focus was not on defending the system against outsiders, but on how to universalize contributions so as to meet the needs of the future. The prominence of contributory reciprocity makes sense of the survey findings that individual responsibility for health is important to German respondents, and the discussion of migrants and refugees in terms of resources not rights may explain why Germans appear to be relatively accepting of public provision of health services for non-citizens. There was some support for allowing private resources to improve the financing of the system, but certainly a strong opposition to better

treatment for higher income groups, the privately-insured and for the privileges of public servants.

In Norway, there was strong support for generalized solidarity, but also high awareness of the limits of the commons, and the need to manage resources for a sustainable future. Although foreigners were not singled out in the Democratic Forums, the need to protect the commons—also a topic of Norwegian public discourse—may explain the relatively high resistance to providing healthcare to non-citizens, and the negative comments in the Forums about privileged access by journalists and celebrities. Despite the country's wealth, survey respondents report not being able to access health services because of long waiting lists, yet the Democratic Forums make it clear that they accept the need to set priorities in order to be in shape for the tremendous demographic shifts of the decades to come, at the same time that they question the ability of government to establish ethical criteria for rationing.

Finally, in Slovenia, we observe support for universal healthcare and dissatisfaction with parts of the existing contributory system, as well as unease with what has been lost from the past with the entry of capitalism and profit motives into the healthcare system. Whereas survey results show a lack of barriers to health access in Slovenia, the Democratic Forums demonstrate that private healthcare lacks public legitimacy. Thus, there is a tension between the objective improvement of health services in Slovenia since the double transition to capitalism and democracy, and the resentment of private for-profit medicine that conflicts with equalitarianism. And indeed, the public-private mix in health in Slovenia contains the lowest proportion of public tax financing, and highest proportion of private health insurance expenditures among the four observed countries; thus, the transition has been extremely radical, indeed.

In sum, the Democratic Forums reveal important sources of worry and dissatisfaction that are not apparent from public opinion surveys, but that may affect public discourse and even elections. Some elements of our national patterns may be traced to the structure of the health system, such as the relatively higher concern with capacity and rationing in our two mainly tax-financed national health services (UK and Norway). But others, such as concerns over private health insurance, bear little relationship to the size of this sector. The causal relationship between these visions of solidarity with media debates would make an interesting question for future research. From this four country comparison, despite the high levels of support for public provision of medical care and the strong perception that the sick are a highly deserving group, we observe significant problems of legitimacy in each country: abuse from outsiders in the UK; privileged occupational groups and privately insured in Germany; lack of consideration for limited resources and unfair access by elites in Norway; unfair health insurance contributions, unfair private access, and unfair private profits earned in public institutions in Slovenia. Whether this can be traced to problems of financial resources in those systems or to a need for better communication of the rationales and justifications for health policies by political leaders would require further studies. What we do know however, is that the future of these healthcare systems will depend upon making significant adjustments and justifying these in ways that are compatible and acceptable within the normative frameworks of these visions of solidarity.

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